STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

iiTS # _____

INCIDENT AND INVESTIGATION TRACKING SYSTEM - REPORT FORM

CLIENT STATE ID#, SSN OR CHART #	CLIENT NAME LAST	FIRST	MI	AGE	SEX ☐ Male ☐ Female

PROGRAM CATEGORY (Check only one)
☐ Inpatient/Resident
☐ Outpatient
☐ Community Placement/SCL
☐ POS
☐ Case Management
☐ CPR (CPS only)
☐ Previous Client

ADA (only)
☐ CSTAR
☐ Residential
☐ Detoxification

Non-DMH Residential Status
MRDD (only)
☐ Natural Home
☐ Private Placement

PROGRAM/UNIT/WARD/COTTAGE	STATE PROVIDER/FACILITY NAME	CONTRACT PROVIDER NAME & VENDOR NUMBER

RESIDENTIAL PROVIDER NAME & VENDOR NUMBER	RESPONSIBLE PROVIDER

INCIDENT TYPE (CHECK ONLY ONE)

DEATH	INJURY	NON-INJURY
☐ Accident	☐ Accident	☐ Accident
☐ Choking	☐ Assault	☐ Choking
☐ Homicide	☐ Choking	☐ Client Rights
☐ Med. Error	☐ Homicide Attempt	☐ Elopement
☐ Prev.Med.Cond.	☐ Med. Error	☐ Homicide Attempt
☐ Restraint	☐ Restraint	☐ Med. Error
☐ Suicide	☐ Self Inflicted	☐ Restraint
☐ Natural Causes	☐ Suicide Attempt	☐ Suicide Attempt
☐ Other	☐ Suspicious	☐ Misuse of Client Funds
	☐ Other	☐ Other

DEATH EXPLANATION (CHECK ALL THAT APPLY)
☐ Critically Ill before Death
☐ Hospital at Time of Death
☐ Seen by Physician within 24 Hrs
☐ Unexpected

SUSPECTED INCIDENT
☐ Neglect
☐ Physical
☐ Sexual
☐ Verbal

ADMISSION STATUS
☐ Civil Involuntary
☐ Voluntary
☐ Vol. By Guardian
☐ Juvenile Court
☐ NGRI
☐ Incompetent To Proceed
☐ Pretrial Evaluation
☐ Criminal Court Ordered (ADA only)

INCIDENT DATE	TIME OF INCIDENT	LOCATION OF INCIDENT	COUNTY
____/____/_____	_____ ☐ a.m. _____ ☐ p.m.		

DIVISION	LOCAL INVESTIGATION	INFORMANT NAME AND RELATIONSHIP	INFORMANT TELEPHONE #
CPS	☐ Yes ☐ No		( )

DESCRIPTION OF INCIDENT

Use additional pages if needed

PERSONS/AGENCIES CONTACTED
☐ Client ☐ Court ☐ District/Reg.Mgr/Admin ☐ Div. Of Aging ☐ Family/Guardian ☐ Law Enforc. ☐ SCL
☐ Coroner ☐ DFS ☐ Div. Director ☐ Fac. Admin. ☐ Forensic CS Manager ☐ Physician ☐ Other

SIGNATURE, TITLE OF REPORTER	TELEPHONE #	DATE
	( )	____/____/_____

If Law Enforcement was contacted:		
Who contacted Law Enforcement? Name	Date of Contact ___/___/_____	Time of Contact ☐ a.m. ☐ p.m.
Complaint was received and reviewed by: Name	Date ___/___/_____	Time ☐ a.m. ☐ p.m.

Employees(s) alleged to be involved in alleged incident:

Last Name	First Name	MI	Social Security #	Sex	Race	Date of Birth
						___/___/___

Address	Telephone Number	Agency
	( )	

Last Name	First Name	MI	Social Security #	Sex	Race	Date of Birth
						___/___/___

Address	Telephone Number	Agency
	( )	

Last Name	First Name	MI	Social Security #	Sex	Race	Date of Birth
						___/___/___

Address	Telephone Number	Agency
	( )	

Witness(s) or other persons having knowledge of the alleged incident:

Last Name	First Initial	Middle Initial

Address	Telephone Number	Agency
	( )	

Last Name	First Initial	Middle Initial

Address	Telephone Number	Agency
	( )	

Last Name	First Initial	Middle Initial

Address	Telephone Number	Agency
	( )	

Name of Complainant	Address of Complainant	Telephone #	Date
		( )	___/___/___

Name of Person Assisting Complainant	Date
	___/___/___

Comments:

Signature of Facility Head (Optional)	Date
	___/___/_____